LEARN TO CODE

Optical Dispensing

American Academy of Ophthalmic Executives®
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Optical Dispensing

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Reviewed and revised Nov. 2019
INTRODUCTION
Challenges in coding are not limited to Evaluation and Management (E/M) documentation requirements, testing services or surgical coding. With the increasing number of ophthalmologists establishing optical dispensaries, knowledge of another range of codes and compliance is necessary.

HCPCS (pronounced “hick-picks”) is the acronym for the Healthcare Common Procedure Coding System. The system provides a uniform method for health care providers to report professional services, procedures and supplies.

“V” codes in the HCPCS system are used to bill for frames and lenses. As coverage varies slightly by state, you should contact your Durable Medical Equipment Regional Carrier (DMERC) for your area’s specifications.

DME Regions
Contracts were awarded to two Medicare Administrative Contractors (MACs) that break into four jurisdictions.

CGS Administrators:
• Jurisdiction B: Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio and Wisconsin
• Jurisdiction C: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia and West Virginia

Noridian Healthcare Solutions:
• Jurisdiction A: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont
• Jurisdiction D: Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington and Wyoming

For up-to-date information, visit www.cms.gov/center/dme.asp

Medicare-Enrollment Requirements for Physician-Owned Optical Dispensary
Effective March 25, 2011, ophthalmologists and optometrists who supply Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DME-POS), as well as postcataract optical services and who are newly enrolling or revalidating (every three years), are subject to a $500 enrollment fee. If you are currently enrolled in Medicare and the Provider Enrollment, Chain, and Ownership System (PECOS) and do not have to revalidate as a DME-POS supplier, you will not see an immediate impact.

While the Centers for Medicare & Medicaid Services (CMS) place most physicians at the lowest level of risk, the agency puts all current or revalidating physicians who supply DMEPOS as part of their services (eg, physicians who provide) in the moderate level of risk. Newly enrolling DMEPOS suppliers will be placed in the highest level of risk, which includes fingerprinting, regardless of whether the supplier is a physician, or not.

What This Means
Low-risk providers (most physicians) are now subject to:
• Verification of any physician/supplier-specific requirements established by Medicare
• License verifications (may include licensure checks across states)
• Database checks to verify:
  – Social Security Number (SSN)
  – National Provider Identifier (NPI)
  – National Practitioner Databank (NPDB) information
  – Office of the Inspector General (OIG) exclusion
  – Taxpayer Identification Number (TIN)
  – Other information, such as recent deaths and other practice changes
Moderate-risk providers, (includes DMEPOS suppliers), are subject to the above, plus:
• Unscheduled or unannounced site visits
• $500 enrollment, adjusted annually based on the consumer price index
High-risk providers are subject to items listed above, plus:
• Fingerprint-based criminal-history record check of law enforcement repositories
CMS released a MLN Matters SE1417 stating that high-risk providers are those newly enrolled in DME. Other reasons for being listed as high-risk include:
• An imposed payment suspension within the last 10 years
• Exclusion from Medicare by the OIG
• Billing privileges were revoked by CMS within the previous 10 years
• Exclusion from any Federal Health Care program
• Subjected to any final adverse action, in the previous 10 years
• Termination or otherwise precluded from billing Medicaid
Practices must be enrolled in DME in order for a patient to use their postcataract benefit. If a patient purchases the glasses from a practice that is not enrolled, they will not be able to submit for reimbursement on their own. The application form, CMS 855S, can be found at www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html. You can also enroll or revalidate with PECOS.
For any practice that fills a glasses prescription for a patient outside their practice, you must have a Surety Bond.

Advance Beneficiary Notice
The current version of the ABN has Exp. 03/2020 printed in the lower left-hand corner. All ABNs with the release date of 03/2011 that are issued on or after June 21,2017 will be considered invalid.
Key features of the ABN:
• It should only be used for Medicare Part B beneficiaries.
• It should be used for every beneficiary who is purchasing glasses or contact lenses, and all fields must be completed. Incomplete ABN will likely result in an overpayment request during an audit.
• It should be used when a patient has selected to purchase noncovered items. Most DMERC carriers list the HCPCS codes that are defined as noncovered in the Local Coverage Determination (LCD) policy regarding DMEPOS.
• It should be used if the practice suspects that they may have an issue getting paid for services rendered to Medicare Part B beneficiaries due to diagnosis and/or frequency of the service performed.
There are three options for the patient to choose:
Option 1. I want the services as outlined. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less copays or deductibles.
Note:
If a beneficiary is required to have an official decision from Medicare in order to file with the secondary policy they should select Option 1. When reviewing the ABN with the patient you are responsible for doing everything you can to clearly explain the transaction that is occurring.
Option 2. I want the services as outlined, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
Note:
This option allows a patient to receive item(s)/service(s) and pay for them out-of-pocket instead of having a claim submitted to Medicare.
Option 3. I don't want the services as outlined. I understand with the choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.
The form has a mandatory field for:
• The optical shop name, address and phone number(s)
• the description of the service(s) provided
• reason(s) Medicare may not pay
• cost estimates of the items/services to be performed
• selection of provided option
• beneficiary signature and date
Medicare instructs physicians not to use general statements on the ABN. A statement, such as “Medicare may not pay,” is too general and does not provide enough information to allow the beneficiary to make an informed decision about whether or not to proceed with the service.
Example of statement that is acceptable:
• Medicare Part B usually does not pay for this service.
The ABN is a Medicare approved form and cannot be altered, however there are specific fields of the ABN that can be customized ahead of time to
### Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn’t pay for D. below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. below.

<table>
<thead>
<tr>
<th>D.</th>
<th>E. Reason Medicare May Not Pay</th>
<th>F. Estimated Cost</th>
</tr>
</thead>
</table>

**WHAT YOU NEED TO DO NOW:**
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS:** Check only one box. We cannot choose a box for you.

- **OPTION 1.** I want the D. listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- **OPTION 2.** I want the D. listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- **OPTION 3.** I don’t want the D. listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**H. Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

<table>
<thead>
<tr>
<th>I. Signature:</th>
<th>J. Date:</th>
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</thead>
</table>

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: **1-800-MEDICARE** or email: [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566
A. Notificante:
B. Nombre del paciente:  
C. Número de identificación:

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**Nota:** Si Medicare no paga D. a continuación, usted deberá pagar. 
Medicare no paga todo, incluso ciertos servicios que, según usted o su médico, estén justificados. 
Prevemos que Medicare no pagará D. a continuación.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>D.</td>
<td>E. Razón por la que no está cubierto por Medicare:</td>
</tr>
<tr>
<td>F. Costo estimado</td>
<td></td>
</tr>
</tbody>
</table>

Lo que usted necesita hacer ahora:
- Lea la presente notificación, de manera que pueda tomar una decisión fundamentada sobre la atención que recibe.
- Háganos toda pregunta que pueda tener después de que termine de leer.
- Escoja una opción a continuación sobre si desea recibir D. mencionado anteriormente.

**Nota:** Si escoge la opción 1 ó 2, podemos ayudarlo a usar cualquier otro seguro que tal vez tenga, pero Medicare no puede exigirnos que lo hagamos.

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**G. Opciones:** Sirvase marcar un recuadro solamente. No podemos escoger un recuadro por usted.

- **OPCIÓN 1.** Quiero D. mencionado anteriormente. Puede cobrarme ahora, pero también deseo que se cobre a Medicare a fin de que se expida una decisión oficial sobre el pago, la cual se me enviará en el Resumen de Medicare (MSN). Entiendo que si Medicare no paga, soy responsable por el pago, pero **puedo apelar a Medicare** según las instrucciones en el MSN. Si Medicare paga, se me reembolsarán los pagos que he realizado, menos los copagos o deducibles.
- **OPCIÓN 2.** Quiero D. mencionado anteriormente, pero que no se cobre a Medicare. Puede solicitar que se le pague ahora dado que soy responsable por el pago. **No tengo derecho a apelar si no se le cobra a Medicare.**
- **OPCIÓN 3.** No quiero D. mencionado anteriormente. Entiendo que con esta opción no soy responsable por el pago y **no puedo apelar para determinar si pagaría Medicare.**

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**H. Información adicional:**

En esta notificación se da a conocer **nuestra opinión, no la de Medicare.** Si tiene otras preguntas sobre la presente notificación o el cobro a Medicare, llame al **1-800-MEDICARE (1-800-633-4227)** o **TTY: 1-877-486-2048.** 
Al firmar abajo usted indica que ha recibido y comprende la presente notificación. También se le entrega una copia.

- I. Firma:  
- J. Fecha:

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CMS no discrimina en sus programas y actividades. Para solicitar esta publicación en un formato alternativo, por favor llame al: 1-800-MEDICARE o escriba al correo electrónico: AltFormatRequest@hhs.gov.

De conformidad con la Ley de reducción de los trámites burocráticos de 1995, nadie estará obligado a responder en todo pedido para recabar información a menos que se identifique con un número de control OMB válido. El número de control OMB válido para esta recolección de información es 0938-0566. El tiempo necesario para completar esta solicitud de información se calcula, en promedio, 7 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar en fuentes de datos existentes, recabar los datos necesarios y llenar y revisar los datos recogidos. Si tiene comentarios sobre la precisión del cálculo del tiempo o sugerencias para mejorar el presente formulario, sírvase escribir a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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*Formulario CMS-R-131 (Exp. 03/2020) Formulario aprobado OMB N° 0938-0566*
accommodate for practice protocol and flow. The form is currently available in English and Spanish. Physicians/staff should document any translation assistance provided in the “Additional Information” section of the ABN.

Modifier -GA is still required on any claim submitted notifying Medicare Part B that the optical dispensary has an ABN on file and should be billed with the appropriate eye modifier.

It is required to review the ABN with the beneficiary in its entirety prior to the beneficiary signing the ABN. All questions and concerns should be addressed prior to the signing of the ABN.

The ABN must be presented to the beneficiary far enough in advance to allow the beneficiary to make an informed decision and to consider all of the choices presented to them.

The patient name must appear listed on the ABN exactly as it appears on the patient’s insurance card, including any middle initials.

The identification number of the patient may never be the Medicare numbers (HICNs) or SSN. Use your internal patient tracking number in this field.

The estimated cost should be listed as a general estimate that would typically be within 25 percent or $100 of the actual cost. Over-estimates are not concerning because the patient ultimately benefits from paying less than expected.

The ABN can be found at aao.org/abn.

MEDICARE COVERAGE FOR EYEGLASSES FOLLOWING CATARACT SURGERY

Pseudophakic Patients

Medicare Part B will pay for one complete pair of eyeglasses per eye surgery, unless cataract surgery is performed on both eyes at the same time (rarely done). In this case, Medicare Part B will pay for only one pair of eyeglasses. There is no time limit for the patient to use this benefit.

If a patient has a cataract extraction with intraocular lens (IOL) insertion in one eye, followed by a subsequent cataract extraction with IOL insertion in the other eye, and did not receive eyeglasses or contact lenses between the two surgical procedures, Medicare Part B will only cover one pair of eyeglasses or contact lenses after the second surgery. It would not be expected to see an order for glasses after the first eye knowing the second eye is already planned.

If the patient has a pair of eyeglasses, undergoes a cataract extraction with IOL insertion, and receives only new lenses but not new frames after the surgery, the benefit would not cover new frames at a later date (unless it follows subsequent cataract extraction in the other eye).

If the patient has cataract surgery on the right eye on June 1, they are eligible for one pair of eyeglasses. If the cataract in the left eye is removed on August 2, and the patient already filed for a pair of glasses after first surgery, the patient is eligible for another complete pair of eyeglasses.

The date of service is the date the glasses are ordered. Included on the claim form in box 19 is the date of surgery.

Medicare Part B will not pay for remakes or refinements of lenses owing to changes after surgery.

Tints (V2744), anti-reflective coating (V2750), or oversize lenses (V2780) are covered only when they are medically necessary for the individual patient and when the medical necessity is documented by the treating physician.

These items should be appended by modifier -KX and submitted on a separate claim.

Note:

If the supplier has obtained a physician’s order for some, but not all, of the items provided to a particular beneficiary, the supplier must submit a separate claim for the items dispensed without a physician order.

Ultraviolet (UV) lenses (V2755) are considered reasonable and necessary following cataract extraction; therefore, additional medical necessity justification by the treating physician beyond inclusion on the order is not necessary.

Tinted lenses, used as sunglasses provided to an aphakic patient in addition to regular prosthetic lenses, will be denied as not medically necessary.

Tinted lenses used as sunglasses prescribed to a pseudophakic patient in addition to regular prosthetic lenses will be denied as noncovered items.

Aphakic Patients

An aphakic patient is one who does not have an IOL implant, or who has a congenital absence of the lens.

For aphakic patients, the following lenses or combinations of lenses are covered when determined to be medically necessary:

• Bifocal lenses in frames
• Lenses in frames for far vision and lenses in frames for near vision
• When contact lenses for far vision are prescribed, (including cases of binocular and monocular aphakia), payment will be made for the contact lenses, and lenses in frames for near vision to be worn at the same time as the contact lenses, and lenses in frames to be worn when the contacts have been removed.

When medically necessary, Medicare Part B will cover replacement of lenses.
Eyeglasses are covered even though the surgical removal of the natural lens occurred before Medicare entitlement.

Scratch resistant coating (V2760) and transition/progressive lenses (V2781) are noncovered as deluxe items.

Only standard frames (V2020) are covered. Additional charges for deluxe frames (V2025) are noncovered.

**Diagnosis Codes**

Covered diagnoses are limited to:

- **Pseudophakia** ICD-10 Z96.1. ICD-10 codes for supporting documentation Z98.41, Z98.42
- **Aphakia** ICD-10 H27.01, H27.02, H27.03
- **Congenital aphakia** ICD-10 Q12.3

Lenses provided for other diagnoses will be denied as noncovered items.

**Patient Payment and Explanation of Medical Benefits**

The Remittance Advice (RA) form details data that patients receive when they order any luxury eyewear. In the following example, dollar amounts are for instructional purposes only.

<table>
<thead>
<tr>
<th>JUNE 1, 2002</th>
<th>BILLED</th>
<th>APPROVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2020 Frame</td>
<td>$100.00</td>
<td>$80.00</td>
</tr>
<tr>
<td>V2203 Bifocals</td>
<td>$ 70.00</td>
<td>$ 45.00</td>
</tr>
<tr>
<td>V2799 High index</td>
<td>$ 65.00</td>
<td>$ 0.00</td>
</tr>
</tbody>
</table>

For the June 1 example, determine whether the optical department will or will not accept assignment. Best practice is to verify that an ABN was obtained for noncovered materials, as this will determine the amount you collect from the patient. Clearly explained patient financial responsibility can allow you to collect up front.

Billing patients, instead of collecting money up front, will render an optical shop cash-poor quickly and should be avoided. Many offices have a simple, direct statement printed on their receipts: “Any balance remaining after insurance payments are received is the patient’s responsibility.”

**HCPCS V CODES**

Codes listed in this section do not necessarily indicate insurance coverage.
| V2201 | Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens |
| V2202 | Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens |
| V2203 | Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens |
| V2204 | Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens |
| V2205 | Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens |
| V2206 | Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens |
| V2207 | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens |
| V2208 | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens |
| V2209 | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens |
| V2210 | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens |
| V2211 | Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens |
| V2212 | Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens |
| V2213 | Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens |
| V2214 | Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens |
| V2215 | Lenticular, per lens, bifocal |
| V2216 | Aniseikonic, per lens, bifocal |
| V2217 | Bifocal seg width over 28 mm |
| V2218 | Bifocal add over 3.25d |
| V2219 | Specialty bifocal (by report) |
| V2300 | Sphere, trifocal, plano to plus or minus 4.00d, per lens |
| V2301 | Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d, per lens |
| V2302 | Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00d, per lens |
| V2303 | Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens |
| V2304 | Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25 to 4.00d cylinder, per lens |
| V2305 | Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens |
| V2306 | Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens |
| V2307 | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens |
| V2308 | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens |
| V2309 | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens |
| V2310 | Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens |
| V2311 | Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens |
| V2312 | Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens |
| V2313 | Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens |
| V2314 | Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens |
| V2315 | Lenticular, per lens, trifocal |
| V2316 | Aniseikonic lens, trifocal |
| V2317 | Trifocal seg width over 28 mm |
| V2318 | Trifocal add over 3.25d |
| V2319 | Specialty trifocal (by report) |
| V2320 | Variable asphericity lens, single vision, full field, glass or plastic, per lens |
| V2321 | Variable asphericity lens, bifocal, full field, glass or plastic, per lens |
| V2322 | Variable sphericity lens, other type |
| V2323 | Vision Aids |
| V2324 | The following are paid according to insurance carrier discretion. Medically necessary documentation may be required from the prescribing physician. |
| V2325 | V2600 | Hand held low vision aids and other nonspectacle mounted aids |
| V2326 | V2610 | Single lens spectacle mounted low vision aids |
Learn to Code Optical Dispensing

V2615 | Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes, and compound microscopic lens system

Miscellaneous V Codes

V2700 | Balance lens, per lens
V2710 | Slab off prism, glass or plastic, per lens
V2715 | Prism, per lens
V2718 | Press-on lens, Fresnel prism, per lens
V2730 | Special base curve, glass or plastic, per lens
V2744 | Tint, photochromatic, per lens
V2745 | Any tint, excluding photochromatic
V2750 | Anti-reflective coating, per lens
V2755 | UV lens, per lens
V2760 | Scratch resistant coating, per lens
V2761 | Mirror coating
V2770 | Occluder lens, per lens
V2780 | Oversize lens, per lens
V2781 | Progressive lens, per lens
V2799 | Vision service, miscellaneous, such as high index, including glass, plastic, bifocal, and trifocal, and should be used as an add-on code to existing billing.
V5160 | Dispensing fee

Codes V2100–V2218, V2299–V2318, V2399–V2499, V2700 and V2770 describe specific eyeglass lenses. Only one of these codes may be billed for each lens provided.

Codes V2219, V2220, V2319, V2320, V2710–V2760 and V2781 describe add-on features of lenses. They are billed in addition to codes for the basic lens.

Note:
Fresnel press-on prisms may be a covered benefit when appending modifier -KX to V2718. However, billing for press-on prisms may impact payment for ground-in prism coverage due to utilization. Best practice is to obtain an ABN and append modifier -GA as well as -KX.

When billing claims for deluxe frames, use code V2020 for the cost of standard frames and a second line item using code V2025 for the difference between the charge for the deluxe frames and the standard frames.

When billing claims for progressive lens, use the appropriate code for the standard bifocal (V2200–V2299) or trifocal (V2300–V2399) lens and a second line item using code V2781 for the difference between the charge for the progressive lens and the standard lens.

Modifiers

-EY | Used for anti-reflective, tints, oversize lens or polycarbonate not ordered by a provider.
     Since NPI implementation in May 2008, any line items with -EY must be on a separate claim.
-KX | Documentation to support medical necessity.
     Use for anti-reflective coating, tints, and oversize lenses if ordered by provider.
     Use for polycarbonate lenses if ordered by provider (usually for monocular vision)
     To read the OIG report Claim Modifier Did Not Prevent Medicare from Paying Millions in Unallowable Claims for Selected Durable Medical Equipment (A-04-10-04040), dated April 2012, visit http://oig.hhs.gov/oas/reports/region4/41004004.pdf
-GA | Item or service expected to be denied as not reasonable and necessary; ABN on file
-RT | Right side
-LT | Left side

Documentation Requirements

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless “there has been furnished such information as may be

© American Academy of Ophthalmology
necessary in order to determine the amounts due such provider” (42 U.S.C. § 1395l[e]). It is expected that the patient’s medical records will reflect the need for the care provided. The patient’s medical records include the physician’s office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports. This documentation must be available to the DMERC upon request.

The medical record must contain a detailed order for the post-cataract glasses or contact lenses (for aphakia) and must clearly state an order for the patient’s frame. The order must include the diagnosis code and/or a narrative diagnosis for the condition necessitating the lens(es) and frame, and must be signed by the treating physician and kept on file by the supplier. For those providers who are both ordering physician and supplier, the prescription is an integral part of the patient’s record. All submitted claims must include the diagnosis code relating to the need for the item.

A detailed written order (DWO) for the lens(es), including frames, that has been signed and dated by the treating physician must be kept on file by the supplier.

DWO must include:
- Beneficiary’s name
- Physician’s name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items). It should include the diagnosis code and/or a narrative diagnosis for the condition necessitating the lens(es).
- Physician signature and signature date
- All claims must include the diagnosis code relating to the need for the item.
- If aphakia is the result of the removal of a previously implanted lens, the date of the surgical removal of the lens must accompany the claim.
- When billing for glasses, the place of service (POS) is 12. A copy of any ABN given to/signed by the patient must be retained in the patient record. A detailed written order (DWO) is required for the lens(es) and must clearly state an order for the patient’s frame. The order must include the diagnosis code and/or a narrative diagnosis for the condition necessitating the lens(es).

Patient Receipt of Glasses and Proof of Delivery

Documentation that the patient has received the post-cataract eyeglasses must be maintained. The delivery date is the date that the beneficiary or an authorized representative actually picks up the glasses, or the date that the package was shipped in the event of having to mail or use a delivery service. The delivery date is used as the date of service on the claim form.

The Proof of Delivery must be kept on file for seven years, and should include a detailed list of the items being purchased by the Beneficiary. There are three methods of delivery for post-cataract glasses and contact lenses:
- Patient or authorized representative is directly receiving the Item(s) at the optical shop
- The Item(s) are being delivered by either mail service or delivery service
- The Item(s) are being delivered to a nursing facility on behalf of the patient

Beneficiaries should receive a copy of the Proof of Delivery at the time they pick up their glasses or contact lenses. Check with your local DMERC and LCDs for specifications on Proof of Delivery.

Remember that post-cataract glasses cannot be dispensed while the patient is in a skilled nursing facility (SNF).

Optical Evaluation Assessment

Many offices find that a patient questionnaire is helpful in identifying patients’ optical needs. The majority of your day is spent:

| Outdoors/driving | Recommend: Sunglasses, transitional or polarized lenses |
| Sports/yard work/carpentry | Recommend: Protective eyewear |
| Computer or desk work | Recommend: Single vision lenses |
| Sewing | Recommend: Single vision lenses |
| Bothered by glare from: | Recommend: Anti-reflective coating |
- Sun when driving
- Computer screens
- Fluorescent lights
- Headlights at night

Contact Lens Coding

Codes for contact lens fitting, refitting, replacement and modification are available in two coding divisions: Level I CPT and HCPCS. Code selection depends upon the insurance carrier’s requirements.
Level I CPT Codes

The description of “prescription” as identified in CPT codes 92310–92317 includes:

• Specifications of the contact lens including base curve, power, diameter and polymer
• Instruction concerning lens care and training on lens insertion and removal

CPT codes 92310–92317 are not bundled with the E/M or Eye visit code examinations or with code 92015 Determination of refractive state.

Supplying the contact lens may be reported as part of the code. If supply of the contact lens is not included, append modifier -26, indicating that the professional component of the code was provided and not the actual supply of the lens.

Subsequent or follow-up visits should be reported with the appropriate E/M or Eye visit code.

92310 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia

For prescription and fitting of one eye, append modifier -52 showing a reduced service; payment will be affected.

92311 corneal lens for aphakia, one eye
92312 corneal lens for aphakia, both eyes
92313 corneoscleral lens

At one time there were lenses that actually covered the sclera encapsulating the entire eye. Rarely used today.

92314 Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia

For prescription and fitting of one eye, append modifier -52 showing a reduced service; payment will be affected.

92315 corneal lens for aphakia, one eye
92316 corneal lens for aphakia, both eyes
92317 corneoscleral lens

From CPT Assistant Archive—Coding for Ophthalmological Services

Coding for Contact Lens Services

The prescription of contact lenses includes specification of optical and physical characteristics (such as power, size, curvature, flexibility, gas-permeability). It is not a part of the general ophthalmological services.

The fitting of contact lenses includes instruction and training of the wearer and incidental revision of the lenses during the training period. Follow-up of successfully fitted extended wear lenses is reported as part of a general ophthalmological service (92012 et seq).

As indicated earlier, the prescription of contact lenses is not part of the general ophthalmological services. Therefore, the prescription of contact lenses may be reported separately in addition to the general ophthalmological service codes and E/M if performed. If a patient presents for follow-up of successfully fitted extended wear lenses, this is part of the general ophthalmological services using 92012 and 92014, and is not a separately reportable service.

Coding for Spectacle Services (Including Prosthesis for Aphakia)

During determination of the refractive state, the physician examines the patient for refractive error. Some common types of refractive errors are hyperopia (farsightedness), astigmatism, and myopia (nearsightedness). The physician may prescribe corrective lenses to help relieve the symptoms caused by refractive error. As the prescription of lens is included in the determination of the refractive state, it would not be reported separately. However, the fitting of the spectacles themselves is a separately reportable service when performed by the physician and would be reported by using codes 92340, 92341, 92342, 92352, 92353, 92354, 92355, 92358, 92370, 92371.

Prescription of lenses, when required, is included in 92015, Determination of refractive state. It includes specification of lens type (monofocal, bifocal, other), lens power, axis, prism, absorptive factor, impact resistance, and other factors.

Fitting includes measurement of anatomical facial characteristics, writing of laboratory specifications, and final adjustment of the spectacles to the visual axis and anatomical topography. The presence of a physician is not required. Supply of materials is a separate service component; it is not part of the service of fitting spectacles.

HCPCS Codes

Insurance carrier payment policy for each contact code is subject to quantity alert and carrier discretion.
### Learn to Code Optical Dispensing

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2500</td>
<td>Contact lens, PMMA, spherical, per lens</td>
</tr>
<tr>
<td>V2501</td>
<td>Contact lens, PMMA, toric or prism ballast, per lens</td>
</tr>
<tr>
<td>V2502</td>
<td>Contact lens, PMMA, bifocal, per lens</td>
</tr>
<tr>
<td>V2503</td>
<td>Contact lens, PMMA, color vision deficiency, per lens</td>
</tr>
<tr>
<td>V2510</td>
<td>Contact lens, gas permeable, spherical, per lens</td>
</tr>
<tr>
<td>V2511</td>
<td>Contact lens, gas permeable, toric, prism ballast, per lens</td>
</tr>
<tr>
<td>V2512</td>
<td>Contact lens, gas permeable, bifocal, per lens</td>
</tr>
<tr>
<td>V2513</td>
<td>Contact lens, gas permeable, extended wear, per lens</td>
</tr>
<tr>
<td>V2520</td>
<td>Contact lens, hydrophilic, spherical, per lens</td>
</tr>
<tr>
<td>V2521</td>
<td>Contact lens, hydrophilic, toric, or prism ballast, per lens</td>
</tr>
<tr>
<td>V2522</td>
<td>Contact lens, hydrophilic, bifocal, per lens</td>
</tr>
<tr>
<td>V2523</td>
<td>Contact lens, hydrophilic, extended wear, per lens</td>
</tr>
<tr>
<td>V2530</td>
<td>Contact lens, scleral, gas impermeable, per lens</td>
</tr>
<tr>
<td>V2599</td>
<td>Contact lens, other type</td>
</tr>
</tbody>
</table>

Medicare covers plastic polymer contact lenses for aphakic patients.

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>Supply of lens</th>
<th>May require an invoice</th>
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</thead>
<tbody>
<tr>
<td>99070</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92326</td>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2599</td>
<td>Contact lens, other type</td>
</tr>
</tbody>
</table>

### Bandage Contact Lens

CPT 2012 introduced two new codes to replace 92070 Fitting of contact lens for treatment of disease including supply of lens. One code was for a bandage contact lens fitting, and the second code was for keratoconus lens fitting.

- CPT code 92071 Fitting of contact lens for treatment of ocular surface disease.
- Bundled with 92072 Fitting of contact lens for management of keratoconus; initial, and exam code 99211.
- Payable per eye. Submit with modifiers -RT or -LT or modifier -50.
- Report supply of special order lenses separately.

Options for supply of lens:

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99070</td>
<td>Supply code—May require an invoice</td>
</tr>
<tr>
<td>92326</td>
<td>Replacement of contact lens</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>V2500</td>
<td>PMMA, spherical, per lens</td>
</tr>
<tr>
<td>V2501</td>
<td>PMMA, toric or prism ballast, per lens</td>
</tr>
<tr>
<td>V2502</td>
<td>PMMA, bifocal, per lens</td>
</tr>
<tr>
<td>V2510</td>
<td>Gas permeable, spherical, per lens</td>
</tr>
<tr>
<td>V2511</td>
<td>Gas permeable, toric, prism ballast, per lens</td>
</tr>
<tr>
<td>V2512</td>
<td>Gas permeable, bifocal, per lens</td>
</tr>
</tbody>
</table>

### Keratoconus Contact Lens

CPT code 92072 Fitting of contact lens for management of keratoconus; initial

- Payment is inherently bilateral.
- Bundled with exam code 99211 and 92071 Bandage contact lens fitting.
- For subsequent fittings, report using E/M or Eye visit code services.

Options for supply of lens:

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99070</td>
<td>Supply code—May require an invoice</td>
</tr>
<tr>
<td>92326</td>
<td>Replacement of contact lens</td>
</tr>
</tbody>
</table>

<table>
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</tr>
<tr>
<td>V2512</td>
<td>Gas permeable, bifocal, per lens</td>
</tr>
</tbody>
</table>
Learn to Code Optical Dispensing

V2513  Gas permeable, extended wear, per lens
V2530  Scleral, gas impermeable, per lens
V2531  Gas permeable, per lens
V2599  Other, type

Coverage issues:
- Practice may not be a supplier of durable medical equipment.
- HCPCS code may not be recognized.
- Diagnosis codes are not a covered benefit.
- Some payers may require a prior approval and may even request a copy of the invoice.
- Patient is likely to be responsible for payment.

Contact Lens Solutions

Contact lens cleaning solution and normal saline for contact lenses are not covered by insurance plans but may be billed using CPT code 99070. Supplies and materials (except spectacles) provided by the physician over and above those usually included with the office visit or other services rendered. Many states require charging sales tax for these items.

Typical Covered Diagnosis Codes

H04.121, H04.122, H04.123  Dry eye syndrome of lacrimal gland (Tear film insufficiency, NOS)
H16.021, H16.022, H16.023  Ring corneal ulcer
H16.031, H16.032, H16.033  Corneal ulcer with hypopyon
H16.041, H16.042, H16.043  Marginal corneal ulcer
H16.051, H16.052, H16.053  Mooren’s corneal ulcer
H16.071, H16.072, H16.073  Perforated corneal ulcer
H16.111, H16.112, H16.113  Macular keratitis (Areolar, Nummular, Stellate, Striate keratitis)
H16.141, H16.142, H16.143  Punctate keratitis
H16.211, H16.212, H16.213  Exposure keratoconjunctivitis
H16.221, H16.222, H16.223  Keratoconjunctivitis sicca, not specified as Sjogren’s
H18.11, H18.12, H18.13  Bullous keratopathy
H18.421, H18.422, H18.423  Band keratopathy
H18.51  Endothelial corneal dystrophy (Fuchs’ dystrophy)
H18.59  Other hereditary corneal dystrophies
H18.621, H18.622, H18.623  Keratoconus, unstable (Acute hydrops)
H18.731, H18.732, H18.733  Descemetocoele
H18.831, H18.832, H18.833  Recurrent erosion of cornea
M35.01  Sicca syndrome [Sjogren] with keratoconjunctivitis, Excludes1: reactive perforating collagenosis (L87.1)
S05.01X-, S05.02X-  Injury of conjunctiva and corneal abrasion without foreign body—Add 7th final character A, D or S
S05.31X-, S0532X-  Ocular laceration without prolapse or loss of intraocular tissue—Add 7th final character A, D or S
T15.01X-, T15.02X-  Foreign body in cornea—Add 7th final character A, D or S
T26.11X-, T26.12X-  Burn of cornea and conjunctival sac—Add 7th final character A, D or S
T26.61X-, T26.62X-  Corrosion of cornea and conjunctival sac—Add 7th final character A, D or S
Z94.7  Corneal transplant status

MEDICARE ADVANTAGE PLANS

While Medicare Part B has limited coverage benefits, Medicare Advantage plans may offer additional covered services for their beneficiaries. They are administered by third party payers, who often contract with vision plans as a member benefit.

- Routine eye exams: May limit what diagnoses can be submitted. Exams may be as frequent as once per year.
- Glasses, frames and/or contact lenses: Plans may offer one pair every 24 months.

Be sure to confirm with the payer prior to providing services as each plan will vary in offerings.
Optical Company, LLC

PROOF OF DELIVERY

1234 Front Street, San Francisco CA 94109
Phone: (999) 987-6543

655 Beach Street, San Francisco CA 94109
Phone: (999) 987-3456

Patient Name: ___________________________ Date of Birth: ________________

Delivery Address: ________________________________________________________________________________________

City: ___________________________ State: _______ Zip Code: __________-_________

Delivery Date: __________________________ Optician: ___________________________

Description of Pseudophakic/Aphakic Glasses:

FRAME MODEL: __________________________
LENS TYPE: ____________________________
MATERIAL: ____________________________
CASE: ________________________________
LENS CARE KIT: _______________________
QUANTITY: __________________________

METHOD OF DELIVERY – SELECT ONE:

1. Patient or authorized representative is directly receiving item(s) at one of the above locations*
2. The item(s) above are being delivered by either mail service or delivery service **
3. The item(s) listed above are being delivered to a nursing facility on behalf of the patient ***

* An authorized representative is “a person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary.” – Per DME MAC Jurisdiction C Supplier Manual

** If item is being shipped, complete additional shipping form and attach to this POD.

*** If item is being delivered to a nursing facility, complete additional facility form and attach to this POD.

PROOF OF DELIVERY: This is confirmation that I have received the item(s) listed above:

Signature of Patient or Patient Representative __________________________
Date __________________________

If Patient Representative, please indicate relationship to patient: __________________________

**Please see reverse side of this document for Care of Lenses and Frames and Complaint Resolution Protocol

This product(s) and/or service(s) provided to you by Optical Company, LLC are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gov. Upon request it will be our pleasure to furnish you a written copy of the standards.

Figure 3 Sample Proof of Delivery
CARE OF LENSES AND FRAMES:

- Use a clean, soft cloth designed to clean eyeglasses. Our Optical Shop has provided you with an initial cleaning cloth in your Lens Care Kit.
- Avoid using tissues or clothing – this may scratch and/or damage your lenses.
- Use approved eyeglass cleaner (like the one provided in your Lens Care Kit) or a mild detergent with warm water to clean frames and lenses.
- **DO NOT SLEEP IN YOUR GLASSES.**
- Use your eyeglass case when not in use to avoid damages.

COMPLAINT RESOLUTION PROTOCOL:

- For issues regarding your eyeglasses, please contact the Optical Department at the phone numbers listed above. We advise you to contact the office where you ordered your glasses; however for your convenience any of our staff will be able to assist you at either location.
- You may be asked to schedule a follow-up appointment with the physician to determine changes with your eyeglasses prior to any changes, exchange, or refund.
- Warranty or exchange policy may be found in the “About Your Eyeglasses” brochure you received when your order for your glasses was placed.
- You may contact the Optical Manager or Practice Manager for unresolved issues.

*Figure 3 Sample Proof of Delivery (continued)*
Optical Company, LLC
DELIVERY VIA SHIPPING or DELIVERY SERVICE
PROOF OF DELIVERY

1234 Front Street, San Francisco CA 94109
Phone: (999) 987-6543
655 Beach Street, San Francisco CA 94109
Phone: (999) 987-3456

Patient Name: ___________________________  Date of Birth: ___________________________

[Attach all necessary documentation to the back of this form and leave no field blank]

1. Is the item being shipped or is a delivery service being used? __________________________
2. What is the name of the shipping or delivery service being used?
   ____________________________________________________________________________

3. What is the delivery address:
   ___________________________  ___________________________  ___________________________
   Address
   City    State    Zip

4. What is the Optical Company Invoice Number? __________________________
5. What is the tracking number for the delivery? (only complete one)
   CERTIFIED MAIL TRACKING NUMBER: _____________________________________________
   OVERNIGHT MAIL TRACKING NUMBER: _____________________________________________
   DELIVERY SERVICE TRACKING NUMBER: ___________________________________________

6. What item is being shipped:
   FRAME MODEL: ___________________________
   LENS TYPE: ___________________________
   MATERIAL: ___________________________
   CASE: ___________________________
   LENS CARE KIT: ___________________________
   QUANTITY: ___________________________

7. What is the date the item is being shipped? ___________________________

   NOTE: THIS SHIPPING DATE MUST BE THE SERVICE DATE ON YOUR ROUTER

Return receipt requests (i.e., packages requiring a signature) is mandatory for all shipping of items.
Attach the return receipt with patient signature to the back of this form, along with a copy of the invoice from the lab.

OPTICIAN COMPLETING FORM AND SHIPPING ITEM: ___________________________
Signature: ___________________________  Date: ___________________________

Figure 4  Sample Proof of Delivery for Shipping Glasses to Beneficiary
Optical Company, LLC

DELLIVERY TO NURSING FACILITY ON BEHALF OF A BENEFICIARY

PROOF OF DELIVERY

1234 Front Street, San Francisco CA 94109
Phone: (999) 987-6543

655 Beach Street, San Francisco CA 94109
Phone: (999) 987-3456

Patient Name: __________________________  Date of Birth: __________________________

[Attach all necessary documentation to the back of this form and leave no field blank.
You must provide a copy of the completed form to the Nursing Facility prior to leaving]

1. What is the name of the Nursing Facility? _______________________________________________________
2. What is the address/destination of the Nursing Facility?

_______________________________________________________________________________________________________

Address

____________________________________  _________________________ ______________
City      State Zip

3. What is the Optical Company Invoice Number? _________________________________________________

4. What item is being delivered:

   FRAME MODEL: __________________________
   LENS TYPE: __________________________
   MATERIAL: __________________________
   CASE: __________________________
   LENS CARE KIT: __________________________
   QUANTITY: __________________________

5. What is the date the item is being delivered? ____________________________________________________

   NOTE: THIS DELIVERY DATE MUST BE THE SERVICE DATE ON YOUR ROUTER

I acknowledge that I have received the above items for the above named beneficiary, __________________________ and will present them to the beneficiary immediately:

____________________________________________________  __________________________
Nursing Facility Representative (print)  Signature

Title: __________________________  Date: __________________________

Name of Optician Delivering Items to Nursing Facility: __________________________

Signature: __________________________  Date: __________________________

Figure 5 Sample Proof of Delivery to a Nursing Home
Learn to Code Optical Dispensing

Optical Company, LLC
POST-CATARACT GLASSES ITEMIZED ROUTER
The Optician serving you for this transaction is: __________________
1234 Front Street, CA 94109 (999) 978-6543 655 Beach Street, CA 94109 (999) 978-3456
Beneficiary Name: ________________________________       Identification Number: __________________

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
<th>Medicare Allowable</th>
<th>Patient Responsibility</th>
<th>Non-Covered Patient Responsibility</th>
<th>Sales Tax</th>
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</thead>
<tbody>
<tr>
<td>V2020</td>
<td></td>
<td>Frame (Base Medicare Allowable)</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>V2025</td>
<td>GA</td>
<td>Deluxe Frame</td>
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<td>GART</td>
<td>Lens Feature:</td>
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<td>Lens Feature:</td>
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<td></td>
</tr>
</tbody>
</table>

Total Each Column: $ $ $ $ 

Ordering Physician
Dr. John
Dr. Smith
Dr. Williams

Total Charges: $ __________________
Total Due from Patient: $ __________________
Total Payment Received: $ __________________
Balance Due (if any): $ __________________

Method of Payment Received:
Cash  Check#___________  VS  MC  AMEX  DISC

I, ____________________________ understand that Medicare pays 80% of allowed charges. Medicare Replacement Plans and Supplemental Insurance will be filed and it will be the patient’s responsibility for any and all charges not paid by insurance.

All deductibles, co-pays, and non-covered services are the patient’s responsibility.

Figure 6 Sample Optical DMERC Router
**Learn to Code Optical Dispensing**

![Sample Insurance Claim Form](image)

**XYZ Insurance Company**

567 Insurance Lane
Big City, IL 60605

---

**1. MEDICARE**

- **Provider Name:** XYZ Insurance Company
- **Address:** 567 Insurance Lane, Big City, IL 60605
- **Phone:** (000) 987-6543

**2. MEDICAID**

- **Provider Name:** XYZ Insurance Company
- **Address:** 567 Insurance Lane, Big City, IL 60605
- **Phone:** (000) 987-6543

**3. TRICARE**

- **Provider Name:** XYZ Insurance Company
- **Address:** 567 Insurance Lane, Big City, IL 60605
- **Phone:** (000) 987-6543

**4. CHAMPION**

- **Provider Name:** XYZ Insurance Company
- **Address:** 567 Insurance Lane, Big City, IL 60605
- **Phone:** (000) 987-6543

**5. GROUP HEALTH PLAN**

- **Provider Name:** XYZ Insurance Company
- **Address:** 567 Insurance Lane, Big City, IL 60605
- **Phone:** (000) 987-6543

**6. OTHER**

- **Provider Name:** XYZ Insurance Company
- **Address:** 567 Insurance Lane, Big City, IL 60605
- **Phone:** (000) 987-6543

---

**XYZ Insurance Company**

- **Insurance Lane:** 567 Insurance Lane, Big City, IL 60605
- **Phone:** (000) 987-6543

---

**Learn to Code Optical Dispensing**

---

**Public, John Q.**

- **Address:** 655 Beach Street, San Francisco, CA 94109
- **Phone:** (000) 987-6543

---

**Figure 7** Sample Insurance Claim Form

---

*Note: Any item with modifier -EY must be on a separate claim.*
**Figure 8** Sample Insurance Claim Form—Humana

Learn to Code Optical Dispensing
Learn to Code Optical Dispensing

Figure 9 Sample Insurance Claim Form—Medadvantage

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*Note: Any item with modifier -EY must be on a separate claim.
Learn to Code Optical Dispensing

Figure 10  Sample A Insurance Claim Form—Noridian Admin Services

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NORIDIAN ADMIN SERVICES
P.O. Box 6727
FARGO, ND 58108

PUBLIC, JOHN B.
655 BEACH STREET
SAN FRANCISCO, CA 94109

© American Academy of Ophthalmology
Learn to Code Optical Dispensing

Figure 11 Sample B Insurance Claim Form—Noridian Admin Services

*Note: Any item with modifier -EY must be on a separate claim.
Figure 12 Sample C Insurance Claim Form—Noridian Admin Services

**Learn to Code Optical Dispensing**
Figure 13 Sample D Insurance Claim Form—Noridian Admin Services

*Note: Any item with modifier -EY must be on a separate claim.
Learn to Code Optical Dispensing

**Figure 14** Sample Insurance Claim Form—Sterling Option 1

*Note: Any item with modifier -EY must be on a separate claim.*
Figure 15: Sample Insurance Claim Form—Secure Horizons
Figure 16 Sample Insurance Claim Form—Select Med
ASK THE CODING EXPERTS

The Academy's coding experts provide weekly up-to-date answers to frequently asked questions. These carefully researched responses cover federal and commercial payers and provide valuable tips on how to improve documentation, submit clean claims and appropriately maximize reimbursement. Visit Coding News and Expert Advice at aao.org/coding to view the most recent FAQs and submit your questions.

Q. Who is responsible for payment of a Fresnel prism?
A. It depends upon the payer. Payment is typically the patient's responsibility.

Q. If a beneficiary still needs post-cataract eyewear following the insertion of a Presbyopia-correction IOL, will Medicare cover the expenses?
A. Yes, Section 1861(s)(8) permits payment of one pair of eyeglasses or contact lenses following cataract surgery with an insertion of any type of intraocular lens.

Q. When are glasses a covered benefit?
A. Medicare will cover one pair of glasses after each cataract is removed.
The covered diagnoses are limited to:
- Z96.1 Pseudophakia
- H27.01–27.03 Aphakia
- Q12.3 Congenital aphakia
If the patient has a diagnosis other than these, the claim may be denied.
Replacement glasses and lenses are noncovered.

Q. How do we code for aphakic contact lens fitting?
A. CPT code 92311 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye.
CPT code 92312 Corneal lens for aphakia, both eyes.
Remember that the supply of contact lenses may be reported as part of the service—or it may be reported separately by using the appropriate supply codes such as V2520–V2523.

MEETING A SAFE HARBOR UNDER THE ANTI-KICKBACK STATUTE

Taken from “Stark Bans on Self-Referrals” Claire H. Topp, Esq., and Dorsey & Whitney LLP (2001 Dorsey and Whitney LLP)
The following arrangements meet a safe harbor under the Anti-Kickback Statute:

Employees
An ophthalmologist may compensate their employees, including ophthalmologists, optometrists, and opticians, for referrals to items sold by the optical shop. The safe harbor protects any amount paid by an employer to an employee who has a bona fide employment relationship with the employer for employment in the furnishing of any item or service for which payment may be made, in whole or in part, under a governmental health program.
The regulators noted in the comments to the safe harbor that the safe harbor permits an employer to pay an employee in whatever manner they choose for having that employee assist in the solicitation of program business.

Independent Contractors/Management Agreements
An ophthalmologist may not compensate an ophthalmologist, optometrist, or an optician who is an independent contractor based on referrals to items sold by the optical shop that are reimbursable by a governmental health program.
To meet the safe harbor for professional service arrangements, the agreement with the independent contractor would have to meet all of the following seven standards applicable to personal service arrangements:
1. The arrangement is embodied in a written agreement signed by the parties.
2. The term of the agreement is for not less than one year.
3. The agreement covers all of the services the agent provides to the principal for the term of the agreement and specifies the services to be provided by the agent.
4. If the agreement is intended to provide for the services of the agent on a periodic, sporadic, or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of the intervals, their precise length, and the exact charge for the intervals.
5. The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purposes of the services.
6. The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arm's-length transactions, and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under the Medicare/Medicaid program.
7. The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any federal or state law. Similarly, if an ophthalmologist entered into a management agreement for the management of the optical shop, the management agreement would have to meet the seven requirements described above. Most notably, the regulators have indicated that a percentage of net revenues compensation provision does not qualify for this safe harbor because the compensation would not be an aggregate amount, fixed in advance, as the safe harbor requires.

Optical Shop Owned by a Solo Practitioner
An ophthalmologist may receive a dividend payment from his or her ownership of a solo practice that operates an optical shop, if the following two standards are met:
1. The equity interests in the practice are held by licensed health care professionals who practice in the practice or group.
2. The equity interests are in the practice or group itself, and not some subdivision of the practice or group.

Optical Shop Operated as Part of Group Practice
An ophthalmologist may receive a dividend payment from his or her ownership of a group practice that operates an optical shop, if, in addition to the two requirements discussed above for solo practitioners, the practice:
1. Meets the definition of “group practice” in Stark II; and
2. Is a unified business with centralized decision-making, pooling of expenses and revenues, and a compensation/profit distribution system that is not based on satellite offices operating substantially as if they were separate enterprises or profit centers.

Thus, although Phase I of the Stark II regulations excludes conventional eyeglasses and contact lenses provided to Medicare patients furnished after cataract surgery from the prohibitions of Stark II, an ophthalmologist owner of a group practice from which he or she will receive a dividend payment does not qualify for the exception unless his optical shop is owned by an entity that qualifies as a “group practice” under Stark II.

Specifically, Phase I of the Stark II regulations defines a “group practice” based on nine characteristics that are briefly described below:
1. Single legal entity. The group practice must be a single legal entity formed primarily for the purpose of being a physician group practice in any organizational form recognized by the state in which the group practice achieves its legal status. The single legal entity may not be organized or owned (in whole or in part) by another medical practice that is an operating physician practice regardless of whether the medical practice meets the conditions for a group practice.
2. Physicians. The group practice must have at least two ophthalmologists who are members of the group (whether employees or direct or indirect owners).
3. Range of care. Each ophthalmologist who is a member of the group (which includes independent contractors) must furnish substantially the full range of patient care services that the ophthalmologist routinely furnishes, including medical care, consultation, diagnosis, and treatment, through the joint use of shared office space, facilities, equipment, and personnel.
4. Services furnished by group practice members. Substantially all of the patient care services of the ophthalmologists who are members of the group (that is, at least 75 percent of the total patient care services of the group practice members) must be furnished through the group and billed under a billing number assigned to the group, and the amounts received must be treated as receipts of the group.
5. Distribution of expenses and income. The overhead expenses of, and income from, the practice must be distributed according to methods that are determined before the receipt of payment for the services giving rise to the overhead expenses or producing the income.
6. Unified business. The group practice must be a unified business having at least the following features: (a) centralized decision-making by a body representative of the group practice that maintains effective control over the group's assets and liabilities (including, but not limited to, budgets, compensation, and salaries); (b) consolidated billing, accounting, and financial reporting; and (c) centralized utilization review. Although Phase I of the regulations expressly indicates that location and specialty-based compensation practices are permitted with respect to revenues derived from services that are not designated health services and may be permitted with respect to revenues that are designated health services in limited circumstances, the Anti-Kickback Statute safe harbor requires that there is a compensation/profit distribution system that is not based on satellite offices operating substantially as if they were separate enterprises or profit centers.
7. Volume or value of referrals. No ophthalmologist who is a member of the group practice directly or indirectly receives compensation based on the volume or value of referrals by the ophthalmologist, except as provided under the special rule for productivity bonuses and profit shares (discussed in 9. below).

8. Physician–patient encounters. Members of the group must personally conduct no less than 75 percent of the ophthalmologist–patient encounters of the group practice.

9. Special rule for productivity bonuses and profit shares. An ophthalmologist in a group practice may be paid a share of “overall profits” of the group or a productivity bonus based on services that he or she has personally performed, provided that the share or bonus is not determined in any manner that is directly related to the volume or value of referrals of designated health services by the ophthalmologist. A share of the “overall profits” means the group’s entire profits derived from designated health services payable by Medicare or Medicaid or the profits derived from designated health services payable by Medicare or Medicaid of any component of the group practice that consists of at least five ophthalmologists. Compensation is not directly related to the volume or value of referrals of designated health services by the ophthalmologist if the revenues derived from designated health services constitute less than 5 percent of the group practice’s total revenues, and the allocated portion of those revenues to each ophthalmologist in the group practice constitutes 5 percent or less of his or her total compensation from the group.

Ophthalmologist/Group Practice Ownership of Separately Incorporated Optical Shops

The safe harbor discussed above, which protects an ophthalmologist’s ownership of a group practice, including an optical shop operated as part of the group practice, expressly does not protect investments made by members of a group practice jointly in separately incorporated optical shops or other separate entities. Furthermore, an ophthalmologist’s or group practice’s ownership of a separately incorporated optical shop does not meet any safe harbor. Although a failure to meet a safe harbor does not necessarily mean that the arrangement violates the Anti-Kickback Statute, such failure does raise uncertainty as to whether the arrangement does not violate the Anti-Kickback Statute and thus whether the arrangement is excluded from Stark II.

It is worth noting that where an ophthalmologist does not expressly refer the patient to the optical shop from which the patient ultimately receives Medicare- or Medicaid-covered eyeglasses or contact lenses but signs the prescription for the eyeglasses or contact lenses, the Phase I regulations indicate that the regulators will presume that the patient received their eyeglasses or contact lenses as a result of the ophthalmologist’s referral to that optical shop. Although the regulators will permit an ophthalmologist to rebut that presumption by establishing that they mentioned no specific optical shop or that the patient was directly referred by some other independent individual or through an unrelated entity, it may be difficult to rebut the presumption if the optical shop where the patient had their prescription filled is located near the ophthalmologist’s office. In addition, state law may require that the ophthalmologist disclose their ownership in the optical shop.

In summary, the new exception created by Phase I of the Stark II final regulations to exclude one pair of conventional eyeglasses and contact lenses furnished after cataract surgery gives ophthalmologists more flexibility regarding the operation of their optical shop; however, group practices owned by for-profit corporations will still need to comply with the definition of “group practice” found in the Stark II regulations described above if they want certainty that they fall within the Stark II exception.

In addition to “prosthetics, orthotics, and prosthetic devices,” Stark II applies to ten other designated health services including inpatient or outpatient hospital services, clinical laboratory services, and radiology and certain other imaging services. Phase I of the Stark II final regulations clarifies that the term “designated health services” does not include services that are reimbursed by Medicare as part of a composite rate, for example, ambulatory surgical center services. Further, although Stark II applies to IOLs implanted in a hospital, Phase I clarified that Stark II does not apply to intraocular lenses implanted in an ambulatory surgical center on the grounds that the payment for IOLs is fixed when implanted in an ambulatory surgical center because it is covered under the fixed ambulatory surgical center payment rate. The exception is for IOLs furnished by the referring ophthalmologist or a member of the referring ophthalmologist’s group practice in a Medicare-certified ASC with which the referring ophthalmologist has a financial relationship provided that (1) the IOL is implanted in the patient during a surgical procedure performed in the same ASC where the IOL is furnished; (2) the arrangement for the furnishing of the IOL does not violate the Anti-Kickback Statute; and (3) billing and claims submission for the IOLs complies with all federal and state laws and regulations.
VALIDITY OF ORDERS

Optical suppliers must maintain documentation that proves authenticity and validity of orders, as well as claims for seven years. Medicare may review orders for validity during an onsite inspection and will accept the following forms of proof:

- An original document (handwritten in ink)
- A photo copy
- A faxed image
- Electronically maintained document

Patients must sign an acknowledgment indicating they have received:

- A copy of the completed ABN form (if applicable)
- A copy of Medicare supplier standards
- Their eyeglasses.

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</table>

ABN ▼ Supplier Standards ▼ I acknowledge receipt of the eyeglasses described above.

Received ___________________________ Received ___________________________

Date ___________________________ Date ___________________________